

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 15 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

14867

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 97

1. PLACE OF DEATH:

(a) County JASPER
(b) City or town CARTHAGE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
WELLS DRUG CO.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community LIFETIME years, months or days)

3. (a) PRINT FULL NAME ROBERT PERRY BUDLONG

3. (b) If veteran, name war None 3. (c) Social Security No. 490-10-2024

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Bertha Condon Budlong 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased AUGUST 5, 1878 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 8 14 hr. min.

9. Birthplace Carthage, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Drug Clerk

11. Industry or business

MOTHER FATHER { 12. Name Charles Budlong
13. Birthplace X Miss. (City, town, or county) (State or foreign country)
14. Maiden name Letitia Wilkinson
15. Birthplace X Penn. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Robert Budlong
(b) Address 1221 So. Maple St., Carthage, Mo.
17. (a) Burial (b) Date thereof 4-21-44 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Ed. C. Ulmer
(b) Address Carthage, Missouri

19. (a) April 21 '44 (b) E. Elizabeth Couplin (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Carthage (If outside city or town limits, write "RURAL")
(d) Street No. 1221 So. Maple St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19, year 1944 hour 2 minute 12 P. M.

21. I hereby certify that I attended the deceased from Sept, 1942 to April 19, 1944 that I last saw him alive on April 19, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 15 min
Due to Hypertension 5 yrs +
Due to Arteriosclerosis 5 yrs +

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) (e) Means of Injury

23. Signature E. Elizabeth Couplin (M. D. or other) MD
Address Carthage Date signed 4/21/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

44-4358

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

E. L. L. L. L.

Licensed Embalmer No.....

2222

P. O. Address.....

Carthage

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.